



2009 Coverage Guide

for the OPERS health care plan

General OPERS Health Care Plan Information..... 1

The OPERS Wellness Program 9

OPERS Medical and Pharmacy Plans

Aetna Medicare Open Plan.....10

Aetna/Medical Mutual Health Care Plans12

Express Scripts Pharmacy Coverage.....15

Alternate Health Care Plans

AultCare PPO16

Kaiser Permanente HMO.....17

Aetna Vision Plan.....18

Aetna Dental Plan.....20

Aetna Long-Term Care Plan23

Glossary – Commonly Used Terms24

Commonly Asked Questions25

Medicare D Notice Of Creditable Coverage.....26

Notice Of Medical Privacy Practices.....28

Qualifying for health care coverage

As an OPERS benefit recipient, you may only receive primary coverage from one of the five Ohio retirement systems (OPERS, STRS, SERS, OP&F, and OSHPRS). If you or your spouse qualifies for retirement under another Ohio retirement system, you may not waive coverage under that system in order to make OPERS your primary health care coverage. You must continue coverage under the other retirement system, but may elect OPERS as secondary.

If you are eligible for health care coverage from more than one OPERS benefit, you may choose the account that provides the lowest cost, but cannot be covered under more than one account simultaneously.

Service Retirement

If you retire on a service retirement and have worked at least 10 years for an OPERS employer, you can apply for the OPERS health plan at the time you retire. You should know, however, that there are some special limits on service that has been purchased. For example, the 10 years may not include out-of-state or military service purchased after January 29, 1981; service credit given under a retirement incentive plan, or credit purchased after May 4, 1992 for exempt service.

If you choose payment option A, C, D or F, your beneficiary will be eligible for health care coverage (as long as you were eligible for coverage) after your death only if your beneficiary meets the definition of an eligible dependent defined in the Ohio Administrative Code 145-4-09 and Section 152 of the Internal Revenue Code. See page 2 for information regarding eligible family members.

If you choose Plan B, your beneficiary will not be eligible for health care coverage or a monthly benefit after your death. If you choose Plan E, your beneficiary will be eligible for health care coverage only if your death occurs before the end of the guaranteed period you selected, as long as you were eligible for health care and your beneficiary meets the definition of an eligible dependent. Once the guaranteed period expires, your beneficiary will not be eligible for health care coverage.

Even if you do not qualify for our health plan, you will still be able to apply for our dental, vision, and long-term care plans if you receive a monthly OPERS retirement check.

Disability Retirement

If you receive a disability check from OPERS, you will be able to join our health plan.

Survivor Benefits

If you die while you are still working, your dependents who are eligible for a monthly benefit may be able to enroll in our health plan if the recipient of the survivor benefit meets the definition of an eligible dependent defined on page 2.

Waiving your right to OPERS health care coverage

You may waive your right to health care coverage provided by OPERS. If you do this, you will waive your right to any health, medical, hospital, surgical or prescription coverage. This will be true for your dependents as well. We will not be able to pay claims for you or your family once you have waived our coverage. We will also not be able to reimburse you for the cost of your Medicare B premium if you waive our health coverage. The waiver does not include the vision, dental or long-term care plans.

If you waive your OPERS health care coverage, you may cancel your waiver by sending OPERS a health care enrollment application at the following times:

- During our annual open enrollment period for health care (October). In this case, you will be able to enroll in our health plan beginning Jan. 1 of the next year.
- Within 31 days after your health coverage is canceled by another group plan. We will ask for evidence of this cancellation (which must be involuntary on your part) at the time you send us your health care enrollment application. In this case, you can enroll in our health plan on the first of the following month (if we receive your application by the fifteenth of the month). For example, if we receive your health plan application (along with proof that your health plan was involuntarily terminated) on April 12, we will enroll you in our plan effective May 1. If we do not receive your application until April 17, you will not be enrolled in our plan until June 1.

Eligible family members

In accordance with the Ohio Administrative Code 145-4-09 and Section 152 of the Internal Revenue Code, if you receive a monthly age and service or disability benefit, you may only enroll:

- Your legal spouse. This must be a person of the opposite gender and you must have a valid marriage certificate recognized by Ohio law (not a marriage license).

Note: Effective Jan. 1, 2011, OPERS will no longer subsidize the monthly health care premium cost for specified spouses of retirees who are under the age of 55. This change will affect spouses of retirees who are currently retired and those who will retire in the future. Retirees may continue to cover their spouse under the OPERS health care plan, but they will be responsible for the full health care premium. Once their spouse reaches age 55, we will again subsidize their health care coverage premium.

Who is affected:

- Spouses of age and service retirees who are under the age of 55 as of Jan. 1, 2011
- Spouses, under the age of 55 as of Jan. 1, 2011, of retirees who converted from a disability benefit to an age and service benefit and,
- Spouses, under the age of 55 as of Jan. 1, 2011, of survivor benefit recipients whose health care coverage subsidy has been grand-fathered

Eligible family members *(continued)*

- Your biological or legally adopted child or minor grandchild if the grandchild is born to an unmarried, unemancipated minor child and you are ordered by the court to provide coverage pursuant to Ohio Revised Code Section 3109.19.

In order for a child to be eligible for coverage, the child must be under 18 and never married or under age 22, never married, and attending an accredited school on a full time basis for at least 5 months of the calendar year. Certain farm training programs qualify as accredited schools. Coverage may be extended if the child is permanently and totally disabled prior to the limiting ages listed above. This means that the child is not able to work in any substantial gainful activity because of a physical or mental impairment, which has lasted or is expected to last for at least 12 months. Evidence of the incapacity is required and is subject to approval by OPERS.

For all children:

You must be allowed to claim this child as a dependent on your federal tax return in accordance with Section 152 of the Internal Revenue Code. The child cannot provide more than half of his/her own support for the calendar year and your child must reside with you for more than half of the calendar year (unless residing at school) with the following exceptions:

- You are divorced, legally separated, separated under a written separation agreement, or living apart at all times during the last 6 months of the calendar year and you are the parent of the child.
- The child is in the custody of you or his/her other parent for more than one-half of the calendar year.
- You provide more than one-half of the child's support, subject to the provisions of Section 152 of the Internal Revenue Code regarding multiple support agreements.

If you receive a monthly benefit as a surviving spouse of a deceased retiree or deceased member, you may only enroll those dependents who would have been eligible dependents of the deceased retiree or member as defined above.

It is your responsibility to notify OPERS, in writing, within 30 days of the date your dependent fails to meet eligibility requirements. Failure to notify OPERS could result in overpaid health care claims for which you will be responsible.

Medicare coverage

Medicare is a health insurance program for people:

- age 65 or older.
- under age 65 with certain disabilities.
- with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

For questions about Medicare, please call:
1-800-MEDICARE

For questions about Medicare, please call:
1-800-MEDICARE

Medicare coverage *(continued)*

When you or your covered spouse become eligible for Medicare, in most cases, the OPERS health plan will pay after Medicare. In the case of the OPERS Medicare Open Plan, the payment made by Medicare is combined with Aetna's payment. It is important that you and your covered spouse apply for Medicare three months (or 90 days) before you reach age 65. If you refuse Medicare coverage because of active employment, you and your covered spouse (if eligible) should enroll before the employer's health plan ends.

OPERS will contact you and your spouse (if he or she is covered under our health plan) before your 65th birthday. We will ask about Medicare coverage at that time. If you or any of your covered dependents become eligible for Medicare before reaching age 65, you must tell OPERS immediately by sending us proof of your Medicare enrollment (a copy of the Medicare card).

There are three parts to Medicare:

Medicare Part A is hospital coverage. You need at least 40 quarters of Social Security credit to be eligible for Medicare A coverage at no cost. You may also qualify for Medicare A coverage through a spouse's work record. If you do not have enough quarters to receive premium-free Medicare A, you must send proof of this (a letter from Social Security) to us. Once this letter is received, your OPERS health plan will provide substitute coverage for Medicare A. Centers for Medicare and Medicaid Services (CMS) regulations do not allow us to enroll retirees in some HMOs if they are not eligible for free Medicare A.

Medicare Part B is medical coverage. Everyone is eligible to enroll in Medicare B once they have reached age 65 (or have a qualifying illness or disability, as discussed above). **You must enroll in Medicare B when it is first offered. If you do not sign up, refuse or stop your Medicare B enrollment, we still consider you to be eligible for Medicare B.** You will still be considered eligible for Medicare B if you refuse coverage because you are covered by an employer's plan. The OPERS health plan will estimate what Medicare would have paid and will subtract that amount from total charges before making a payment. In this case you would be responsible for the amount that would have been paid by Medicare B. If you or your covered dependents do not enroll in the Medicare B program when it is first offered, you cannot be enrolled in an HMO or in the Aetna Medicare Open Plan.

Medicare Part D is prescription drug coverage. OPERS does not recommend that our benefit recipients sign up for Medicare Part D because it requires an additional premium. The OPERS health care plan already provides prescription drug coverage that is better than Medicare Part D and does not require an additional premium.

However, there is one exception. Depending on your financial status you may be eligible for free Medicare Part D coverage may benefit from accepting this plan as it is very generous. If you qualify for Medicare Part D with no premium required, we encourage you to accept it in place of OPERS prescription coverage. See page 28 for more information on Medicare Part D.

Medicare B Reimbursement

If you are receiving a monthly benefit and are enrolled in the OPERS health plan you may be reimbursed for the basic cost of your Medicare B coverage. We can only provide this reimbursement if your Medicare B premium is not being covered (in any part) by another organization. Also, we will not reimburse you if another organization (such as Medicaid) is paying the Part B premium on your behalf. OPERS will pay you back for the basic cost of your Medicare B premium (once you provide proof of your enrollment and a signed statement indicating that you are not receiving reimbursement from any other source) by adding the amount to your monthly benefit check. OPERS does not provide this reimbursement benefit to spouses. If you terminate your Medicare B coverage or if you begin receiving reimbursement from another source for your Medicare B premium, you must notify OPERS immediately. You will be responsible for any reimbursement amount paid to you after Medicare B coverage has ceased or you have begun receiving reimbursement from another source.

The Medicare Direct Program

If you are enrolled in the OPERS Aetna or Medical Mutual plan and are also covered by Medicare, our Medicare Direct program will make medical claim filing easier. If you enroll in this program, Medicare will consider your medical claim and then send information directly to Aetna or Medical Mutual.

Your Medicare Summary Notice will advise you when Medicare begins to forward your claims information to the OPERS Aetna or Medical Mutual Plan. Once Medicare has forwarded your claim information to your health plan, you do not have to file the claim with your plan. Once you are enrolled in this program, it is very important that you notify OPERS if your name and/or Medicare claim number changes. You are only eligible to enroll in this program if the OPERS plan is your secondary coverage after Medicare. You and your covered spouse may enroll in this program at any time, and there is no cost for this service. This program does not apply to the Aetna Medicare Open Plan.

When your health care coverage begins

Health care coverage will begin on your benefit effective date but not more than one year from the date OPERS receives your health care application (HC-1). You may delay your enrollment no more than 60 days after the release of your first benefit payment.

Other important facts to know**Enrolling eligible family members in the medical/pharmacy plan outside of an open enrollment**

After you begin receiving benefit payments, you may only enroll your eligible family members if you have experienced a life change (which we call a “qualifying event”). A qualifying event can be a new marriage or a new child because of birth or adoption or involuntary loss of coverage from another source. You must tell us of such an event, complete an enrollment application, and provide supporting documentation of the qualifying event within 60 days. OPERS needs 31 days to process the application once we receive it. The effective date of your family member’s coverage will be the first day of the next month (after the 31 days are up). If you enroll a new dependent in our health care plan, he or she will be placed into the same level of coverage that you have selected for yourself.

Other important facts to know *(continued)*

Terminating dependents from the medical/pharmacy plan

You must notify OPERS immediately if your covered spouse and/or children become ineligible for coverage due to divorce/dissolution, death or if a child fails to meet eligibility requirements. OPERS will require that you provide a certified copy of your divorce/dissolution decree or your spouse's or child's death certificate. If a child fails to meet the eligibility requirements, OPERS requires notification from you indicating the child's last date of eligibility. If you fail to notify OPERS that a family member is no longer eligible, overpayment of health care or prescription claims could occur and unnecessary premiums could be taken from your benefit check. In addition, you may be responsible for reimbursing OPERS for claims paid.

You may terminate your spouse and/or children's coverage under the OPERS health care plan at any time during the year for any other reason. However, you must provide OPERS with a written request to terminate coverage or you may contact OPERS for a dependent cancellation form. OPERS will terminate your spouse's and/or children's medical/pharmacy coverage within 31 days of your written request or completed cancellation form.

If you are enrolled in either Kaiser or AultCare and wish to terminate your spouse's coverage, Kaiser or AultCare will require you and your spouse's signature to terminate coverage. You must contact OPERS for the appropriate dependent cancellation form. OPERS will terminate your spouse's coverage within 31 days of receiving your completed cancellation form.

Open Enrollment

Open enrollment is held each year during the month of October. We will send you information about your health care choices each year, as open enrollment approaches. Please be sure to read the material carefully, as premiums and plan features often change from year to year.

If you enroll in the OPERS medical plan administered by Aetna or Medical Mutual, you may only select your plan level (Enhanced, Intermediate, or Basic) every other year. You may select your dental and vision coverage every year. If you enroll in the Aetna Medicare Open Plan, you may select another plan after one year. If you selected the Aetna Medicare Open Plan, but your provider does not accept this coverage, we will allow you to change plans mid-year. Please call OPERS for more information.

OPERS Health Care Plan Seminars

OPERS offers two different health care plan seminars - one for active Traditional Pension and Combined Plan members and one for OPERS retirees. If you would like to know more about the OPERS health care plan, our health care education team invites you to attend a seminar.

Health care seminars are held throughout the year in locations all around Ohio. Please visit www.opers.org or call OPERS for a list of dates and locations. Registration is required. Please call 1-800-222-7377 for more information.

Re-employment

If you go back to work in an OPERS-covered position, you must enroll in your employer's health plan if the employer offers a health plan to other employees in similar positions to yours. You cannot waive your employer's plan unless you have other health coverage that will pay first, before the OPERS health plan. **If your employer offers health coverage and you do not enroll in it, your OPERS health coverage will be reduced by the amount that would have been covered by your employer's plan.** You do not have to provide coverage for your dependents under your employer's health plan. OPERS will not provide you or your eligible dependents health care coverage during a suspension or forfeiture of your retirement allowance.

Important things to remember after coverage begins

- Identification cards will automatically be sent to you by your plan administrator once your first monthly benefit has been released. Please contact your administrator if you need additional identification cards.
- If you are enrolled in an HMO and move outside of the service area, you must contact OPERS immediately to change your health plan.
- If you and/or your spouse are enrolled in the Medicare Direct program, be sure to contact OPERS if your Medicare claim number or name changes with Social Security.

Income Based Discount Program

The OPERS Income Based Discount Program is designed to help qualified benefit recipients pay for their participation in the OPERS Medical/Pharmacy plan. This program provides a 30 percent reduction in the premium amount you pay each month for medical/pharmacy coverage if your 2007 household income was equal to or less than 150 percent of the federal poverty level. Household income includes all income and wages you earned, plus the income and wages of your spouse and any dependent(s) you claimed on your 2007 federal income tax return. To be eligible, your household income must have been at or below the following for the 2007 calendar year:

# of Persons in household	150 percent of poverty level
1	\$15,315.00
2	\$20,535.00
3	\$25,755.00

If you feel that you qualify, you must contact OPERS to receive an *Income Based Discount Program Application*. This form can also be found on the OPERS Web site, www.opers.org. Complete and return this application along with a copy of your 2007 filed federal tax return. If you and your dependents filed separate returns, you must also include your dependent's 2007 federal tax return(s). Be sure to keep a copy of your application. OPERS will retain this original application and the copies of your tax return(s).

Please remember that this program applies to medical/pharmacy premiums only. Premium costs for dental, vision or long-term care do not qualify.

GENERAL INFORMATION

Retiree Medical Account (RMA)

If the medical plan, dental and vision options that you select have a total monthly cost less than your monthly allowance, the excess will be deposited in a Retiree Medical Account (RMA). **Retirees who choose the Enhanced Plan or the Aetna Medicare Open Plan will not have an RMA deposit unless a wellness program is completed.**

How does the RMA work?

The RMA is not a comprehensive health care insurance plan. Instead, it is an account you can use to obtain reimbursement for qualified health care expenses. Since the money may only be used to pay qualified health care expenses, your distributions from the RMA are not subject to federal income taxes. You may submit expenses you incur such as deductibles, out of pocket copayments, or many other qualified health care expenses not otherwise covered by insurance plans.

What are qualified health care expenses?

The RMA allows for a very broad range of expenses that qualify for payment. Many things not covered by traditional insurance plans will meet the standard for payment. In most cases, qualified health care expenses include medical, dental, and vision expenses normally allowed by the Internal Revenue Service (IRS) as deductions on your tax return. Medical expenses may include the premiums (post-tax) you pay for health insurance under the OPERS health care program, deductibles, copayments, premiums for spouses and many medical services. They also can include limited amounts paid for any qualified long-term care insurance contract. For more specific information, please contact Aetna for a complete listing of the medical expenses that may be reimbursed if you have available funds in the RMA. **Note: The one exception to the Aetna list is that the OPERS RMA will reimburse for premiums paid for OPERS coverage.**

How will I keep track of my account?

OPERS has partnered with Aetna to provide the administrative services for the RMA. Aetna is responsible for maintaining a record of the balance in your RMA. They will track contributions, interest, and your reimbursements, and will provide you with regular written statements, mailed to your home address, regarding the status of your account. While you are contributing to your RMA, Aetna will provide you with an annual statement of the vested account balance during the second quarter of the year. After you begin receiving reimbursements from the RMA, you will receive quarterly statements. In addition, you will receive an Explanation of Payment in any month a disbursement occurs.

How do I file a claim?

Aetna provides claim forms. You complete the claim form, attach supporting proof that you have paid for the claimed expense, and if approved, Aetna will reimburse you from your RMA.

Can I cover my dependents' health care expenses with my RMA funds?

You may use your RMA to pay health care expenses for your qualified dependents as defined by OPERS.

Will my beneficiary's health care expenses be covered with my RMA funds?

If you die while contributing or while receiving a payment, your beneficiary may use the remaining vested portion of your RMA account for the payment of qualified health care expenses. Your RMA beneficiary must be a qualified dependent under IRS guidelines.



Aetna Retiree
Medical Account
1-888-672-9136
www.aetna.com

OPERS Wellness Incentive Programs

Healthy Living Healthy Retirement

Healthy Living Healthy Retirement is a program offered to all non-Medicare retirees and covered spouses as part of the OPERS health care plan. *Healthy Living Healthy Retirement* will help these retirees identify potential health risks and offers programs and personalized coaching to help them live a healthier life. OPERS has partnered with Gordian Health Solutions Inc. to administer this program.

As part of participating in a year-long Gordian health-coaching program, retirees will have the opportunity to earn up to a \$100 incentive. Participants will receive a \$50 RMA deposit upon the completion of a Personal Health Analysis and another \$50 deposit when they have completed 12 months of coaching and achieved one goal set by their health coach. If eligible to participate, retirees should contact Gordian at 1-866-560-9355 for complete details about the *Healthy Living Healthy Retirement* program as well as information on how to enroll and qualify for a participation incentive of up to \$100.

OPERS encourages all eligible retirees and spouses to enroll in this program. Enrollment begins with the completion of a Personal Health Assessment. Retirees can be certain that their answers to this health assessment will be completely confidential and that OPERS will not see individual results.

The Aetna Medicare Open Plan Wellness Program

For those retirees who are participating in the Aetna Medicare Open Plan, OPERS offers a wellness program tailored specifically for the Medicare population. This program also offers an opportunity for eligible members and spouses to earn a \$100 incentive for the successful completion of a goal-oriented coaching program. This wellness plan includes the following:

- Fitness programs, including a free fitness club membership (associated with any fitness center in the network), along with access to SeniorPHIT (an on-line exercise and nutrition tool).

In 2009, retirees participating in the Aetna Medicare Open Plan have an expanded network of fitness facilities to choose from for their free membership. The new Aetna Fitness Network includes all fitness centers in their previous Forever Fit Network as well as select YMCA facilities and many gyms that were added per request by retirees. Please contact Aetna at 1-866-282-0631 to find a free fitness center in your area.

- Lifestyle coaching by phone, a program that allows a retiree to work with a life coach to develop a personalized plan to achieve specific goals such as eating better, exercising regularly and quitting smoking.

You will receive more information on the wellness program once you have enrolled in the Aetna Medicare Open Plan. The wellness program for retirees and spouses eligible for Medicare is only offered through the Aetna Medicare Open Plan.



For questions about *Healthy Living Healthy Retirement*, please call:
Gordian Health Solutions
1-866-560-9355



For questions about the Aetna Medicare Open Plan wellness program, please call:
Aetna
1-866-282-0631

We are pleased to be able to offer the Aetna Medicare Open Plan to our Medicare-eligible retirees and their covered, Medicare-eligible spouses in 2009. The Aetna Medicare Open Plan is very similar to the Aetna Enhanced Plan. Perhaps the most noticeable difference is that you no longer need to coordinate with Medicare. The Aetna Medicare Open Plan has the same individual deductible amount as the Aetna Enhanced Plan, no defined provider network, the ease of a single ID card, one Explanation Of Benefits and a single contact for medical coverage needs. Other advantages include a specialized wellness program and a care management program.

Common questions about the Aetna Medicare Open Plan

Can anyone with Medicare choose to join the Aetna Medicare Open Plan?

Retirees who are enrolled in Medicare Part A and B or Part B only and are enrolled in another Aetna plan (Intermediate or Basic), a Medical Mutual Plan, or an alternate plan (Kaiser or Aultcare) are eligible to switch to the Aetna Medicare Open Plan during the annual open enrollment period.

You are not eligible to participate in the Medicare Open Plan if you are Medicare-eligible and your covered spouse is not. If you are enrolling any children in the OPERS health care plan or live outside the United States, you will not be able to enroll in this plan.

Will my doctor accept the Aetna Medicare Open Plan?

The best way to determine if a doctor accepts the Aetna Medicare Open Plan is to contact the provider directly and ask if they will accept the

plan. If the doctor has any questions, he or she should call the Aetna Provider Service Center at 1-800-624-0756.

Is the Shingles vaccine covered under the Aetna Medicare Open Plan?

Zostavax, the vaccine used to treat Shingles, is not currently covered under the Aetna Medicare Open Plan. This plan must follow guidelines that have been set by the Centers for Medicare and Medicaid Services (CMS) and this vaccine is not currently a covered expense. However, this vaccine is covered as a preventive service under the OPERS health care plan (Enhanced, Intermediate, Basic), administered by either Aetna or Medical Mutual.

Expanded fitness center options

The Aetna Medicare Open Plan wellness program offers a free membership at select fitness facilities. Those participating in the plan will have access to a free membership at all fitness facilities within the Aetna Fitness Network. Aetna has added a number of fitness centers in Ohio to the Network for 2009. The additions include select YMCA locations and other facilities that have been added by request. OPERS retirees outside of Ohio will access the original Aetna Forever Fit Network. For more information about the wellness program and free fitness memberships, please see page 9.



For questions regarding the Aetna Medicare Open Plan, please call:

Aetna
1-866-282-0631
www.aetna.com

Plan Features

Deductible per calendar year	
Single	\$250
Out-of-pocket limit per calendar year (excluding deductible)	
Single	\$850
Lifetime Maximum	Unlimited
MEDICAL SERVICES	
Outpatient Hospice	Covered by Medicare at a certified hospice agency, 100%
Mental Health	96%
Substance Abuse (including Alcohol)	96%
Surgery	96%
Office Visit	96%
EMERGENCY SERVICES	
Emergency Rooms	\$50 copayment (waived if admitted)
Urgent Care	\$50 copayment
PREVENTIVE	
Routine Physical Exam	100%
Annual PAP, Mammography, PSA	100%
Colorectal Cancer Screening (for all members age 50 and over)	100%
Bone Density Testing	100%
Flu, Pneumonia, Hepatitis B vaccines	100%
OTHER MEDICAL	
Diagnostic lab and x-ray	Lab/pathology 100%, X-ray 96%
Chiropractors (for manual manipulation of the spine to the extent covered by Medicare)	96%
Physical Therapy	96%
Ambulance	96%
Home Health Care	100%
Durable Medical Equipment	96%
INPATIENT	
Inpatient Deductible	None
Semi-Private Room	96%
Pre-Admission Testing	100%
Skilled Nursing Facility	100% for days 1- 365 for medically necessary care
Hospice (Respite Care)	Covered by Medicare at a certified hospice agency, 100%
<p><i>All charges subject to medical necessity. The prescription drug program will be the same as the OPERS Enhanced Plan administered by Express Scripts. (See page 15)</i></p>	



For questions regarding the Aetna Medicare Open Plan, please call:

Aetna

1-866-282-0631

www.aetna.com

The OPERS medical plan has two administrators, Aetna and Medical Mutual. The coverage structure is the same under both administrators for retirees not eligible for Medicare, or eligible for Part B only. The main differences between the two are the provider networks and your premium cost. **The plan features a choice between three levels of medical coverage - the *Enhanced Plan*, the *Intermediate Plan* and the *Basic Plan*.**

These three plans, their coverage levels, and copayments are described in detail on the following pages. Please review this information carefully before deciding on the best plan for you and your family.

If you are not eligible for Medicare coverage and live within the United States, you will be in the network/PPO plan. The network plan is a program in which a network of doctors and hospitals agree to provide services at discounted fees. These fees tend to be less than the fees of non-network providers.

When a network provider is used, OPERS refers to this coverage as "Network". You may also choose to obtain services from a provider who does not participate in the administrator's network. OPERS refers to this coverage as "Out-of-Network". To determine which providers participate in the network, contact Aetna at 1-877-834-0016 or visit their website at www.aetna.com. The Aetna network is called **Choice POS II**.

You may contact Medical Mutual at 1-800-854-8139 or visit their website at www.mmoh.com. Medical Mutual's Ohio network is called **Supermed Plus**. If you live outside of Ohio, you should refer to the logo on your identification card for the appropriate network.

If you are over 65 and do not qualify for Medicare A coverage, you must use network hospitals, skilled nursing and hospice facilities in order to receive the highest level of coverage. Non-network facilities will be paid at the "Out-of-Network" level. You will not be required to use participating medical providers (examples include: physicians, laboratory services and radiology) since Medicare B is your primary coverage.

Medicare Eligible or Out-of-Area Coverage
Networks are not available if you live outside of the United States. There are also some areas in the United States that do not have established networks. **In the event that Aetna or Medical Mutual do not have a network in your area, your coverage will be "Out-of-Area"**. If you are eligible for Medicare and not enrolled in the Medicare Open Plan, then Medicare (in most cases) pays first and the OPERS health care plan pays second. OPERS refers to your coverage as "After Medicare".



1-877-834-0016
www.aetna.com



1-800-854-8139
www.mmoh.com

AETNA/MEDICAL MUTUAL HEALTH CARE PLAN FEATURES

RETIREES ELIGIBLE FOR MEDICARE OR LIVING "OUT-OF-AREA"

UCR – Usual and Customary Rate - UCR limits generally apply to any service provided out-of-network.	OPERS Medical Plans		
	Enhanced	Intermediate	Basic
Deductible per calendar year	\$250 single / \$400 family	\$400 single / \$800 family***	\$900 single / \$1,800 family***
Out-of-Pocket limit per calendar year	\$850 single / \$1,600 family	\$1,000 single / \$2,000 family***	\$1,500 single / \$3,000 family***
Lifetime Maximum	\$3,000,000	\$3,000,000	\$3,000,000
MEDICAL SERVICES			
Outpatient Hospice	80%	80%	80%
Mental Health	80%	80%	70%
Substance Abuse (including alcohol)	80% / \$1,000 outpatient maximum per year	80% / \$1,000 outpatient maximum per year	70% / \$1,000 outpatient maximum per year
Surgery	80%	80%	70%
Office Visit	80%	80%	60%
EMERGENCY SERVICES			
Emergency Room	\$75* co-pay / 100% facility 80% all other services	80%	70%
Urgent Care	80%	80%	60%
PREVENTIVE** (must be billed as routine)			
Routine Physical	\$100 each year	\$100 each year	\$100 each year
Annual PAP, Mammography, PSA	100%	100%	100%
EKG, Cholesterol, Blood Sugar, Lipid, Colonoscopy, Sigmoid, Bone Density Testing	100%	100%	100%
Flu, Pneumonia and Shingles Vaccines	100%	100%	100%
OTHER MEDICAL			
Lab and Diagnostic	80%	80%	70%
Chiropractors (10 visit limit)	80%	80%	70%
Physical Therapy	80%	80%	70%
Ambulance	80%	75%	70%
Home Health Care	First 100 visits at 100%. Additional visits at 80%	80%	70%
Durable Medical Equipment	80%	80%	70%
Medically Necessary Wigs	\$100 per year no deductible	\$100 per year no deductible	\$100 per year no deductible
All Other	80%	80%	70%
INPATIENT			
Inpatient Deductible (per admission)	\$100	\$100	\$100
Semi-Private Room	80%	80%	70%
Pre-Admission Testing	80%	80%	70%
Skilled Nursing Facility	100%	80%	70%
Hospice	100%	100%	100%

ALL SERVICES SUBJECT TO MEDICAL NECESSITY. *Waived if admitted **Not subject to co-insurance or deductible ***In families with both Medicare and Non-Medicare enrollees, the PPO network or out-of-network amounts need to be met.

Note: Medicare benefit recipients are not subject to any difference in coverage based on network providers. The OPERS health care plan pays secondary to Medicare and follows their schedule for allowable charges.

AETNA/MEDICAL MUTUAL HEALTH CARE PLAN FEATURES

RETIREES NOT YET ELIGIBLE FOR MEDICARE

UCR – Usual and Customary Rate – UCR limits generally apply to any service provided out-of-network.	OPERS Medical Plans					
	Enhanced		Intermediate		Basic	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Deductible per calendar year	\$250 single \$400 family	\$300 single \$500 family	\$750 single \$1,500 family	\$1,500 single \$3,000 family	\$2,000 single \$4,000 family	\$4,000 single \$8,000 family
Out-of-Pocket limit per calendar year	\$850 single \$1,600 family	\$1,600 single \$3,100 family	\$3,000 single \$6,000 family	\$6,000 single \$12,000 family	\$5,000 single \$10,000 family	\$10,000 single \$20,000 family
Lifetime Maximum	\$3,000,000	\$3,000,000	\$3,000,000	\$3,000,000	\$3,000,000	\$3,000,000
MEDICAL SERVICES						
Outpatient Hospice	80%	70%	80%	70%	80%	70%
Mental Health	80%	60%	80%	60%	70%	50%
Substance Abuse (including alcohol)	80% \$1,000 outpatient max. per year	60% \$1,000 outpatient max. per year	80% \$1,000 outpatient max. per year	60% \$1,000 outpatient max. per year	70% \$1,000 outpatient max. per year	50% \$1,000 outpatient max. per year
Surgery	80%	60%	80%	60%	70%	50%
Office Visit	\$15 co-pay	60%	\$25 co-pay	60%	60%	60%
EMERGENCY SERVICES						
Emergency Room	\$75 co-pay* 100% facility 80% other services	\$75 co-pay* 100% facility 80% other services	80%	80%	70%	70%
Urgent Care	\$35 co-pay	60%	\$45 co-pay	60%	\$50 co-pay	60%
PREVENTIVE** (must be billed as preventive)						
Annual routine physical	\$100	\$100	\$100	\$100	\$100	\$100
Annual PAP, Mammography, PSA	100%	100%	100%	100%	100%	100%
EKG, Cholesterol, Blood Sugar, Lipid, Colonoscopy, Sigmoid, Bone Density Testing	100%	100%	100%	100%	100%	100%
Flu, Pneumonia and Shingles Vaccines	100%	100%	100%	100%	100%	100%
OTHER MEDICAL						
Lab and Diagnostic	80%	60%	80%	60%	70%	50%
Chiropractors (10 visit limit)	80%	60%	80%	60%	70%	50%
Physical Therapy	80%	60%	80%	60%	70%	50%
Ambulance	80%	80%	75%	75%	70%	70%
Home Health Care	100 visits 100% then 80%	70%	80%	60%	70%	50%
Durable Medical Equipment	80%	60%	80%	60%	70%	50%
Medically Necessary Wigs	\$100 per year no deductible	\$100 per year no deductible	\$100 per year no deductible	\$100 per year no deductible	\$100 per year no deductible	\$100 per year no deductible
All Other	80%	60%	80%	60%	70%	50%
INPATIENT						
Inpatient Deductible (per admission)	\$100	\$200	\$100	\$200	\$100	\$200
Semi-Private Room	80%	70%	80%	60%	70%	50%
Pre-Admission Testing	80%	70%	80%	60%	70%	50%
Skilled Nursing Facility	100%	70%	80%	60%	70%	50%
Hospice	100%	70%	100%	70%	100%	70%

ALL SERVICES SUBJECT TO MEDICAL NECESSITY. *Waived if admitted **Not subject to coinsurance or deductible

Retail pharmacy program - You can receive up to a 30-day supply of medication, plus refills, as prescribed by your physician. In order to use the retail pharmacy network, you must present your prescription drug ID card and prescription(s) to the pharmacist.

Mail pharmacy program - You can receive up to a 90-day supply of medication, plus refills, as prescribed by your physician. Mail the prescription(s) and the correct copayment in the special order envelope to Express Scripts.

Note: Express Scripts will always dispense a generic medication unless the written prescription is marked with "Dispense as Written (DAW)". If you choose to purchase a brand name drug when there is a lower-cost generic available, you will be charged the non-formulary brand copayment (subject to plan deductible and copayment if applicable).

2009 OPERS PRESCRIPTION DRUG PLAN			
	Enhanced/ Medicare Open Plan	Intermediate	Basic (after deductible is met)
Deductible	Does not apply	Does not apply	\$550 individual \$1,100 family
Generic	\$3 Retail \$9 Mail	\$10 Retail \$30 Mail	35% copayment
Formulary Brand (Preferred)	\$15 Retail \$45 Mail	\$35 Retail \$105 Mail	35% copayment
Non-Formulary Brand (Non-Preferred)	\$50 Retail \$150 Mail	\$50 Retail \$150 Mail	50% copayment
PPI Coverage	Enhanced/ Medicare Open Plan	Intermediate	Basic (after deductible is met)
OTC Prilosec OTC Omeprazole	\$5 Retail \$15 Mail	\$5 Retail \$15 Mail	\$5 Retail \$15 Mail
Generic Omeprazole and Pantoprazole	\$25 Retail \$75 Mail	\$25 Retail \$75 Mail	\$25 Retail \$75 Mail
Nexium	\$50 Retail \$150 Mail	\$50 Retail \$150 Mail	\$50 Retail \$150 Mail
Prevacid, Aciphex, Prilosec, Protonix and Zegerid	\$75 Retail \$225 Mail	\$75 Retail \$225 Mail	\$75 Retail \$225 Mail



1-866-727-5873
www.express-scripts.com

**Proton Pump
Inhibitors (PPIs) are
subject to different
copayments than
other
medications.**

Non-covered drug program

For prescription drugs not covered by the OPERS health care plan, a non-covered program is available. You can receive up to a 90-day supply through the mail pharmacy at a significant discount. When you use this program, Express Scripts will advise you of the cost prior to dispensing the prescription. You will find the program beneficial when obtaining drugs you wish to use that are not covered by the OPERS health care plan. Please contact Express Scripts directly for more information on this program.

AULTCARE PPO PLAN

If you choose to enroll in an alternate plan, you must obtain enrollment materials from the plan (not OPERS). If you or your spouse will be turning age 65 during 2009, please note your premium will change at that time.



For questions regarding the AultCare PPO Plan, please call:
1-330-363-6360
1-800-344-8858
www.aultcare.com

AultCare PPO Plan

You may enroll in the AultCare PPO plan in place of the OPERS medical plan if you live in the service area. We will advise you at the time of your retirement and again during open enrollment if you are eligible for this plan. If you enroll in the AultCare plan, the plan will provide coverage regardless of which provider you use. However, you will receive the highest level of coverage by using the plan's network providers.

AultCare is available to those residing in the following Ohio counties:

Ashland, Belmont, Carroll, Columbiana, Coshocton, Guernsey, Harrison (partially), Holmes, Jefferson (partially), Mahoning, Medina, Muskingum, Portage, Richland, Stark, Summit, Tuscarawas or Wayne.

For more information:

To receive a complete packet of information call 1-330-363-6360 (local) or 1-800-344-8858 (toll-free) or visit www.aultcare.com

	AultCare Provider	Non-AultCare Provider
Deductible <i>(per calendar year)</i>	\$250 person/\$500 family	\$500 person/\$1000 family
Out-of-Pocket/Co-Insurance <i>(per calendar year)</i>	\$1250 person/\$2500 family	\$2500 person/\$5000 family
Physician Services		
Office Visit/Primary Care	100% after \$15 copayment	60%*
Surgery	80%	60%*
Routine Physical Exam <i>(\$200 per calendar year)</i>	100% (no deductible)	60%*
Hospital Coverage		
Admission Deductible	None	None
Semi-Private Room	80%	60%*
Pre-Admission Testing	80%	60%*
Emergency Room	100%	100%*
Emergency Room (Non-emergency care)	50%*	50%*
Hearing Aid(s)	No coverage	No coverage
Vision and Dental	No coverage	No coverage

**After the calendar year deductible is met. All charges are subject to medical necessity. Prescription Drug Program will be the same as the OPERS Enhanced Plan administered by Express Scripts, Inc. See page 15.*

Kaiser Permanente HMO

Kaiser is an alternative to the OPERS health care plan. We will advise you at the time of your retirement and again during open enrollment if you are eligible for this plan.

Kaiser coverage is more comprehensive than some other group plans and claim filing is handled for you. Vision and dental coverages are included. Kaiser requires that you use their network doctors and facilities to receive coverage. You should not sign up for Kaiser if you expect to be outside the HMO service area for more than 90 days. **Please note the different coverage listed for those who are and are not yet eligible for Medicare.**

Kaiser is available to those residing in the following Ohio counties:

Cuyahoga, Geauga, Lake, Lorain, Medina, Portage or Summit

For more information:

Please call 1-216-621-7100 (local) or 1-800-686-7100 (toll-free) or TTY (216) 479-5003 or visit www.kp.org.

	You Pay	
Health Provider	Network Provider	
Deductible (per year)	\$250 single/\$500 family	(None if Medicare-eligible)
Out-of-Pocket/Co-Insurance (per year)	\$2,000 single/\$6,000 family (None if Medicare-eligible)	
Physician Services		
Office Visit/Primary Care	\$15 copayment	
Surgery	10% after deductible	(\$15 co-pay for outpatient surgery if Medicare-eligible)
Routine Physical Exam	\$15 copayment	
Hospital Coverage		
Admission Deductible	None	
Semi-Private Room	10% after deductible	(None if Medicare-eligible)
Pre-Admission Testing	10% after deductible	(None if Medicare-eligible)
Emergency Room	\$50 co-pay (copayment waived if admitted)	
Hearing - Exam	\$15 copayment	
Hearing Aid	None	
Vision - Exam	\$15 copayment	
Frames and Lenses	Up to \$300/24 months using United Optical	
Dental	100% preventive/70% basic restorative/60% major restorative Must use Delta Dental dentist	

All charges are subject to medical necessity. Prescription Drug Program will be the same as the OPERS Enhanced Plan is administered by Express Scripts, Inc. See page 15.

If you choose to enroll in an alternate plan, you must obtain enrollment materials from the plan (not OPERS). If you or your spouse will be turning age 65 during 2009, please note your premium will change at that time.



For questions regarding the Kaiser Permanente HMO, please call:

Kaiser Permanente
1-216-621-7100
1-800-686-7100
www.kp.org

AETNA VISION PLAN

The Aetna vision plan, which includes a high option plan and a low option plan, is insured by Aetna. Coverage is available for lenses and frames - OR - contact lenses, but not both. The low and high option plans will reimburse a fixed amount for covered services according to the following schedule:

Coverage	Low Option Plan Pays	High Option Plan Pays
Routine eye examinations	\$50	\$65
Frames	\$25	\$78
Lenses		
● Single Vision	\$35	\$45
● Bifocals	\$55	\$60
● Trifocals	\$75	\$80
● Lenticular	\$100	\$150
Contact lenses	\$180	\$228
Coverage period for exams	12 months	12 months
Coverage period for frames & lenses	24 months	12 months

Please note that examinations or treatments related to a medical condition such as glaucoma or cataracts are covered by your medical plan, not your vision plan.



For questions regarding the Aetna Vision Plan, please call:
Aetna
1-800-645-5677
www.aetna.com

Claim Filing Address:
Aetna
PO Box 981107
El Paso, TX 79998

2009 Monthly Premium for the OPERS Vision plan

Vision Coverage	Recipient	Spouse	1 Child	2+ Children
High option	\$ 6.23	\$ 6.23	\$ 4.86	\$ 6.48
Low Option	\$ 2.64	\$ 2.64	\$ 2.07	\$ 2.76

EyeMed Vision Care Program

EyeMed Vision coverage is an enhanced benefit to high or low option vision coverage. If you use an EyeMed provider, your out of pocket expenses will be less. EyeMed providers include many major retailers such as LensCrafters, Target Optical, most Sears Optical and Pearle Vision locations as well as many independent providers. OPERS participates in the EyeMed “Select” network which includes thousands of participating optical locations nationwide. The coverage under the EyeMed Vision Care Program is as follows:

Coverage	Low Option You Pay	High Option You Pay
Routine eye examinations	\$0	\$0
Contact lense examination	Standard exam \$32 copayment Premium exam \$77 copayment	Standard exam \$17 copayment Premium exam \$62 copayment
Frames	\$5 copayment retail value to \$50	\$0 copayment retail value to \$130
Lenses		
● Single Vision	\$5 copayment	\$0 copayment
● Bifocals	\$5 copayment	\$0 copayment
● Trifocals	\$5 copayment	\$0 copayment
Contact lenses	\$10 copayment retail value to \$200	\$0 copayment retail value to \$240
Coverage period for exams	12 months	12 months
Cov. period for frames & lenses	24 months	12 months

Laser Vision Correction

This plan includes a discount for laser vision correction procedures. When applicable, members receive a 15% discount off the price of LASIK or PRK procedures, or 5% off any promotional price, whichever is lower. Services are provided through the U.S. Laser Network, owned and administered by LCA Vision. Simply call 1-877-5LASER6 to begin the process of receiving your discount.

For the most up-to-date list of EyeMed providers, please visit their Web site:
www.eyemedvisioncare.com
 or call:
 EyeMed Member Services
 1-866-723-0514

Aetna Dental Plan

In order to provide you with affordable dental care, the Aetna PPO Dental Plan is offered as an option to you and your eligible family members. The Aetna dental plan provides coverage when you go to any licensed dentist. However, increased coverage and lower out-of-pocket costs are available when you go to an Aetna preferred dentist. Please call Aetna for a list of network dentists.

2009 Monthly Premium for the OPERS Dental plan

Dental Coverage	Recipient	Spouse	1 Child	2+ Children
High option	\$29.51	\$29.51	\$23.02	\$30.69
Low Option	\$17.73	\$17.73	\$13.84	\$18.44

General Information**Aetna PPO Dental Plan and participating dentists:**

Please call 1-800-879-4337 Monday - Friday 8:00 a.m. - 6:00 p.m. or visit Aetna website at www.aetna.com.

Claim Filing Address:


If your dentist is non-participating and does not submit the claims directly to Aetna PPO Dental, you should send the claims to:

Aetna
P.O. Box 14094
Lexington, KY 40512-4094



For questions regarding the Aetna Dental Plan, please call:

Aetna
1-800-879-4337
www.aetna.com

Covered Services	Low Option		High Option		AETNA DENTAL PLAN
	Participating Dentist	Non-participating Dentist	Participating Dentist	Non-participating Dentist	
Diagnostic and preventive care: <ul style="list-style-type: none"> ● routine oral examinations, 2 per year ● emergency palliative treatment ● prophylaxis, 2 per year ● fluoride treatments to age 16 ● bitewing X-rays, one set per year 	100%	80%	100%	100%	 <p>For questions regarding the Aetna Dental Plan, please call: Aetna 1-800-879-4337 www.aetna.com</p>
Oral Surgery <ul style="list-style-type: none"> ● simple extractions ● surgical removal of erupted teeth <p>Oral surgery that is dental in nature may be covered under your dental plan if it is not covered by your medical plan. Major oral surgery not covered; may be covered under medical plan.</p>	60%	50%	80%	65%	
Minor Restorations , including amalgam fillings, composite fillings for anterior teeth and stainless steel crowns.	60%	50%	80%	65%	
Periodontics , including scaling and root planing, subgingival curettage, and gingivectomy.	60%	50%	80%	65%	
Endodontics , including root canal therapy, pulpotomy and apicoectomy; (root canal on molars included but paid at lower benefit). Please note: The number of participating endodontists is very limited.	60%	50%	80%	65%	
Prosthodontics/Major Restorations <ul style="list-style-type: none"> ● inlays, onlays, crowns/full and partial dentures and repairs ● pontics 	25%	25%	50%	35%	
Annual Deductible - does not apply to diagnostic and preventive care.	\$50/\$100	\$50/\$100	none	\$50/\$100	
Calendar Year Maximum	\$1,500	\$1,500	\$1,500	\$1,500	

*Please note: Residents of Texas are not required to obtain services from network providers.

What is Not Covered by the Dental Plan

- Plastic, reconstructive or cosmetic surgery.
- Experimental services, supplies or procedures.
- Treatment for occupational disease or injury.
- Treatment of any jaw joint disorder, such as temporomandibular joint disorder (TMJ).
- Hospitalization, prescription drugs, hospital services and nursing care.
- Services covered under any other plan of group coverage provided by OPERS.
- Replacement of lost, missing or stolen dental appliances or replacement of dental appliances that have been damaged due to misuse or neglect.
- Dentures, crowns, inlays, onlays, bridgework or other appliances or services used for the purpose of splinting.
- Items ordered or dental work begun prior to the effective date of the dental plan but not delivered or completed until after the effective date.
- Services determined not to be necessary.
- Orthodontic treatment.
- All dental services not specifically covered in or that are limited or excluded by your plan documents, including costs of services before coverage begins and after coverage terminates.



For questions regarding the Aetna Dental Plan, please call:

Aetna

1-800-879-4337

www.aetna.com

Dental Disclaimer

This material is for informational purposes only and is neither an offer of coverage nor dental advice. It contains only a partial, general description of plan coverage or programs and does not constitute a contract. Aetna does not provide dental services and, therefore, cannot guarantee any results or outcomes. Consult your plan documents to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan. The availability of a plan or program may vary by geographic service area.

"Aetna" is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. Those companies include Aetna Life Insurance Company. While this material is believed to be accurate as of the print date, it is subject to change.

The Aetna Long-Term Care Plan is designed to help you pay for the costs of long-term care. If you apply within 60 days of your retirement benefit effective date, you will not be subject to medical underwriting. After your first retirement check has been released, please call the Aetna Long-Term Care member service telephone number: 1-800-537-8521 for complete details.

What Is Long-Term Care?

- Long-term care consists of a wide range of personal care, health care and social services for people of all ages who can no longer care for themselves.
- It provides help with usual activities of daily living such as dressing and walking and is often called custodial care.
- It is not just nursing home care, nor is it just for the elderly, although as people age they become more likely to need this type of care.

Qualifying For Coverage Under the OPERS Long-Term Care Plan

To be eligible for coverage, the insured person must first suffer a "qualifying loss" after coverage is effective. This loss must result in the need for continual human assistance in at least two of the following five Activities of Daily Living (ADLs):

- Eating
- Dressing
- Bathing/hygiene
- Transferring (getting in and out of bed or chairs)
- Toileting

A qualifying loss can be caused in two ways:

- By an injury, illness or the effects of aging which makes one physically incapable of performing activities of daily living, or
- By a diagnosed mental impairment, such as Alzheimer's disease, which makes one mentally incapable of performing activities of daily living

How the Plan Covers Your Care

You may select a daily benefit of \$50 to \$250 in \$1 increments. Upon qualifying for coverage, the plan pays 100% of your selected amount for nursing facility care, 80% of your selected amount for care in an assisted living facility, or 50% of your selected amount for care in any other setting (informal care). Your lifetime maximum benefit is a dollar amount based on five years of care in a nursing facility; as a claimant, you may receive care in any combination of settings up to the dollar amount. For example:

Nursing Facility Daily Benefit	Assisted Living Daily Benefit	Informal Care Daily Benefit	5-Year Lifetime Maximum Benefit
\$ 50	\$ 40	\$ 25	\$ 91,250
\$100	\$ 80	\$ 50	\$182,500
\$250	\$200	\$125	\$456,150



For questions regarding the Aetna Long-Term Care Plan, please call: **Aetna**
1-800-537-8521
www.aetna.com

GLOSSARY – COMMONLY USED TERMS

Aetna Medicare Open Plan – the Aetna Medicare Open Plan is a private-fee-for-service (PFFS) Medicare Advantage plan that has been designed exclusively for OPERS by Aetna and the Center for Medicare and Medicaid Services (CMS). Medicare-eligible retirees and their covered, Medicare-eligible spouses are eligible to participate in this plan.

Basic Plan – the OPERS medical plan choice featuring the lowest cost but also the highest copayments, annual deductibles, and out-of-pocket maximums.

Co-insurance - the ratio (%) of splitting the bill between the health coverage administrator and you. For example: 80% for the first \$1,000 means the administrator will pay \$800 and you are responsible for the remaining \$200.

Copayment (co-pay) – a specified out-of-pocket expense for health care services such as doctor visits and prescriptions drugs paid at the time the service is rendered, with the insurance carrier paying the remaining costs.

Deductible – The amount an insured has to pay out-of-pocket for expenses before the insurance carrier will cover the remaining costs.

Enhanced Plan – the most expensive OPERS medical plan choice featuring the lowest copayments, annual deductibles, and out-of-pocket maximums.

Formulary - a list of medications that are preferred by Express Scripts to other drugs in the same class. These medications are preferred based on their effectiveness, availability and cost. The OPERS formulary was created by the Express Scripts Pharmacy and Therapeutics Committee, a group of independent doctors and pharmacists. Medications on this list are referred to as “**formulary medications**”. Medications not included on the formulary list are referred to as “**non- formulary medications**”

Intermediate Plan - the OPERS medical plan choice featuring a lower cost than the Enhanced plan but also higher copayments, annual deductibles, and out-of-pocket maximums.

Lifetime maximum - The maximum amount of money a plan will pay towards health care services over the course of the insured's lifetime.

Member Benefits System (MBS) – a feature of the OPERS Web site that allows retirees to securely view their own personal account information.

Out-of-pocket expense - any medical care costs not covered by insurance, which must be paid by the insured.

Out-of-pocket maximum - the maximum amount of money an insured must pay of costs not covered by insurance.

Preferred Provider Organization (PPO) - a health care plan that contracts with select providers who agree to offer health care services to enrollees at contractually set reimbursement levels. The PPO applies to benefit recipients and eligible dependents who are not eligible for Medicare and who reside in designated network areas.

Retiree Medical Account (RMA) – An RMA is a savings account where funds are accumulated exclusively to pay for qualified health care expenses not covered by your health care plan. If the medical plan, dental and vision options that you select cost less than your monthly allowance, the excess will go into an RMA.

Usual and customary rate (UCR) - the amount that is determined by a health plan to be the usual and accepted charge for a procedure done within a certain geographical area. This is sometimes also referred to as the “prevailing” charge or the “traditional” amount.

How do I know which of the three OPERS medical plan levels would be best for me?

Choosing a plan level is an important decision. If you are considering the *Intermediate* or *Basic Plan*, please read this guide carefully. There are important differences between the three plans. The Intermediate and Basic Plans feature a lower cost, but also higher copayments, annual deductibles, and out-of-pocket maximums.

Under the OPERS medical plan, do I have to choose the same level of coverage for myself and my covered family members?

Yes. If you wish to enroll eligible family members, they must be enrolled in the same OPERS medical plan as you with the same administrator (Aetna or Medical Mutual). This is also true for dental and vision coverage. Your eligible family members must be enrolled in the same option (high or low) as you.

Is the cost of dental and vision coverage included in my medical premium?

No. Dental and/or vision coverage can be purchased at an additional cost. The dental and vision coverage rates for 2009 can be found on pages 18 and 20.

How do I get the \$100 incentive for participating in one of the OPERS wellness programs?

Retirees who are not yet eligible for Medicare may enroll in the *Healthy Living Healthy Retirement* program. Participants will receive a \$50 RMA deposit upon the completion of a Personal Health Analysis and another \$50 deposit when they have completed 12 months of coaching and achieved one goal set by their health coach. Please call Gordian Health Solutions at 1-866-560-9355 for more information.

Individuals eligible for Medicare must enroll in the Aetna Medicare Open Plan in order to qualify for a wellness program and potentially receive a \$100 incentive. Please contact Aetna at 1-866-282-0631 for more information.

Will OPERS reimburse me the full cost of the Medicare B premium in 2009?

OPERS will reimburse the basic premium cost of Medicare B to covered retirees (not spouses) who have submitted proof of their Medicare Part B coverage and who have signed a statement verifying that they are not receiving Medicare B reimbursement from another source. Please remember that if a retiree loses Medicare Part B coverage due to non-payment to Social Security, they will be responsible for reimbursing OPERS for any overpaid money.

Why do some of my prescription medications have a higher copayment than others?

Your copayments for prescription medications vary depending on the status of your medication (Formulary or Non-formulary) and whether you use a participating retail pharmacy or the Home Delivery Program. You will save money by using generic and Formulary (preferred) brand-name drugs. To check the Formulary status of a medication or the estimated price of a prescription, please call Express Scripts toll-free at **1-866-727-5873** or visit www.express-scripts.com.

Notice of Creditable Coverage

This notice is being provided to you by Ohio PERS as required by Medicare. It requires no immediate action on your part. It provides certain protection to you should you wish to enroll in a Medicare prescription plan in the future in place of your Ohio PERS prescription plan. You should keep this with your other important health insurance papers.

Important Notice about our prescription drug coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with OPERS and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. OPERS has determined that the prescription drug coverage offered by the OPERS Express Scripts plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15th through December 31st.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

2009 Ohio PERS Prescription Drug Plan						
	Retail pharmacy copayment 30-day supply			Mail Service copayment 90-day supply		
	Enhanced	Intermediate	Basic*	Enhanced	Intermediate	Basic*
Generic	\$3.00	\$10.00	35%	\$9.00	\$30.00	35%
<i>Brand (no generic available)</i>						
Formulary	\$15.00	\$35.00	35%	\$45.00	\$105.00	35%
Non-formulary	\$50.00	\$50.00	50%	\$150.00	\$150.00	50%

*Deductible of \$550 individual/\$1,100 family applies

You should also know that if you drop or lose your coverage with Ohio PERS and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

For more information about this notice or your current prescription drug coverage:

Contact our office for further information.
NOTE: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through Express Scripts changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage:

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Remember: Keep this notice. If you enroll in one of the plans approved by Medicare which offer prescription drug coverage after May 15, 2006, you may need to give a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date:	May 15, 2006
Name of Entity/Sender:	Ohio Public Employees Retirement System
Address:	277 E. Town Street, Columbus, OH 43215
Phone Number:	1-800-222-7377

NOTICE OF MEDICAL PRIVACY PRACTICES

Ohio Public Employees Retirement System Self-Funded Health Plan Effective Date of Privacy Notice: April 14, 2003

This notice describes how medical information about you may be used and disclosed, and how you can have access to this information. Please review this carefully.

**If you have any questions about this notice, please contact our Medical Privacy Officer at:
Ohio PERS
277 East Town Street
Columbus, OH 43215**

Our Philosophy on Member Privacy

We recognize the importance of Member privacy. As such, it is our policy to treat all medical information as personal and confidential; we are committed to protecting your privacy rights. The Ohio Public Employees Retirement System Self-Funded Health Plan (the "health plan") and its business partners receive Member health information through the operation and administration of the health plan.

We receive health information from you through applications, communications with you and through the processing of claims submitted to the health plan and other information received as part of you being a Member of Ohio PERS. This notice applies to all of the health information used or transmitted by the health plan or its business partners.

Uses and Disclosures of Medical Information

The following categories describe different ways that we use and disclose medical information. Not every possible use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

A. Payment, Health Care Operations and Administrative Matters

The law permits us to use/disclose your medical information or health information for payment and/or health care operations.

(i) For Payment – We may use or disclose health information about you to our business partners that administer the health plan, a governmental payer or other responsible third party for the purpose of receiving payment for the medical treatment you have received or to provide your doctor eligibility information.

(ii) For Health Care Operations – We may use and disclose medical information about you for purposes of health care operations. These uses and disclosures are necessary to ensure that all of our Members receive quality care. Some examples of these uses and disclosures include but are not limited to (1) uses by our enrollee advocates who act as a liaison between the Member and various health plan administrators, (2) quality assessment through the distribution and analysis of Member satisfaction surveys, (3) health care and disease management functions, (4) data management through the Information Technology Systems department. We may also combine your health information with that of other Members enrolled in the health plan to evaluate the benefits provided by the health plan and to evaluate the quality of care our Members receive as a whole.

(iii) For Certain Administrative Matters – We may also use and disclose medical information about you for general administrative activities, including customer service, cost management, auditing and legal services. In addition we may send you information based on your own health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you, or to tell you about health-related benefits or services that may be of interest to you.

B. Other Uses and Disclosures of Medical

Information for which Member Authorization is Not Necessary – In limited instances, we may use and disclose medical information without your Authorization in the following situations:

(i) Uses and Disclosures to Family and Friends – We may disclose to your family member, or close personal friend involved with your medical care, medical information about you that is directly relevant to your family member or friend's involvement with your care or with the payment related to your care. In all instances, before we disclose any medical information about you to your family members or your friends, we will inform you of the disclosure and give you an opportunity to agree or object to the disclosure.

(ii) Uses and Disclosures for Disaster Relief Purposes – For the limited circumstances of disaster relief efforts, we may disclose medical information about you to your close family or friends, or to a public or private disaster relief entity.

(iii) Uses and Disclosures Required by Law – We may use or disclose medical information to the extent that such use or disclosure is required by federal, state, or local law and the use or disclosure complies with and is limited to the relevant requirements of such law.

(iv) Uses and Disclosures for Public Health Activities – We may use or disclose medical information about you to the Public Health Authorities for public health purposes.

(v) Uses and Disclosures for Health Oversight Activities – We may disclose or use medical information to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; or licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

(vi) Disclosures for Judicial and Administrative Proceedings – If you are involved in a legal dispute, we may disclose medical information about you in the course of any judicial or administrative proceeding with a valid court order or appropriate subpoena or discovery request. We will make all reasonable efforts to tell you about this request before making this disclosure.

(vii) Disclosures for Law Enforcement Purposes – We may disclose medical information if asked to do so by a law enforcement official for limited law enforcement purposes.

(viii) Uses and Disclosures for Specialized Government Functions – We may use or disclose medical information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities. We may use or disclose medical information to authorized federal officials for national security and intelligence purposes and for protection of the President of the United States or other heads of state. In some circumstances, we may use or disclose medical information about an inmate or individual that the correctional institution has lawful custody of.

(ix) Uses and Disclosures for Workers' Compensation - We may disclose medical information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs. These programs provide benefits for work-related injuries.

C. Other Uses and Disclosures

Use and disclosure of medical information for purposes not listed above in parts A and B will only be made with your written Authorization. You may revoke this Authorization at any time by providing us with written notice of such revocation. Your revocation shall become effective immediately upon our receipt of such notice, except to the extent that we have already

Member Rights Regarding Private Medical Information

Each Member has the following rights with respect to protected, private health or medical information:

A. Right to Request Restrictions

You have the right to request that we restrict the uses or disclosures of your medical information to carry out treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care, like a family member or friend. For example, you could ask that we not disclose or use information about a certain medical treatment you received. **PLEASE NOTE: We are not required to agree to your request.**

To request restrictions, you must make your request in writing to the Medical Privacy Officer at Ohio PERS. In your request, you must tell us:

- what information you want to limit;
- whether you want to limit our use, disclosure, or both; and
- to whom you want the limits to apply, for example, disclosures to your spouse.

B. Right to Receive Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work. To request confidential communications, you must make your request in writing to the Medical Privacy Officer at Ohio PERS. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. In addition, because we will likely forward your request to the third-party administrator of the health plan, after we receive your request, we may request additional reasonable information from you to process your request.

C. Right to Inspect and Copy Protected Health Information

You have the right to inspect and copy medical information that may be used to make decisions about payment and your care. If you agree in advance, we may provide you with a summary or explanation of your medical information.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Medical Privacy Officer at Ohio PERS.

If you request a copy of the information, we may charge a reasonable fee for the costs of preparing a summary or explanation of your medical information or for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to certain medical information, in many instances you may request that the denial be reviewed.

D. Right to Amend Protected Health Information

You have the right to request an amendment to your medical information if you feel the information is incomplete or incorrect for as long as the information is maintained by the health plan. To request an amendment, your request must be made in writing and submitted to the Medical Privacy Officer at Ohio PERS. If for some reason the health plan, in compliance with state and federal law, rejects your amendment, we shall permit you to submit to us a written statement of disagreement to be kept with your medical information. The health plan may reasonably limit the length of such statement of disagreement.

**OPERS
Retirement Board**

The 11-member OPERS Retirement Board is responsible for the administration and management of OPERS. Seven of the 11 members are elected by the groups that they represent (i.e., college and university non-teaching employees, state, county, municipal, and miscellaneous employees, and retired members); the Director of the Department of Administrative Services for the state of Ohio is a statutory member, and three members are investment experts appointed by the Governor, the Treasurer of State, and jointly by the Speaker of the Ohio House of Representatives and the President of the Ohio Senate.

**Elected
Board Members**

Eddie Parks
State Employees

Sharon M. Downs
Retired members

John W. Maurer
Retired members

Kimberly Russell
State College and
University Employees

Cynthia Sledz
Vice Chair
Miscellaneous Employees

Ken Thomas
Chair
Municipal Employees

Helen Youngblood
County Employees

**Statutory
Board Member**

Hugh Quill
Director, Department
of Administrative
Services

**Appointed
Board Members**

Lennie Wyatt
Investment Expert
Governor Appointee

Charlie Adkins
Investment Expert
Treasurer of State Appointee

James R. Tilling
Investment Expert
General Assembly Appointee

Chris DeRose
Chief Executive Officer

This booklet is written in plain language for use by benefit recipients of the Ohio Public Employees Retirement System. It is not intended as a substitute for the federal or state law, namely the Ohio Revised Code, the Ohio Administrative Code, or the Internal Revenue Code, nor will its interpretation prevail should a conflict arise between it and the Ohio Revised Code, Ohio Administrative Code, or Internal Revenue Code. Rules governing the retirement system are subject to change periodically either by statute of the Ohio General Assembly, regulation of the Ohio Public Employees Retirement Board, or regulation of the Internal Revenue Code. If you have questions about this material, please contact our office or seek legal advice from your attorney.



Ohio Public Employees
Retirement System
277 East Town Street
Columbus, OH 43215-4642